§ 1300.65.1. Cancellation Complaint Form

(a) A request that the Director review cancellation of, or refusal to renew, an enrollment or subscription pursuant to subdivision (b) of Section 1365 of the Act shall be made in writing, signed by the subscriber or enrollee or the legal representative of the subscriber or enrollee and it shall be in the following form (or in letter form containing the information specified in the form below):

STATE OF CALIFORNIA
Department of Managed Care

To: Health Plan
Division

Date: _____
Today's Date – Month Day, Year

Department of Managed Care
980 9th Street, Suite 500
Sacramento, CA 95814
Fax: (916) 229-0465

RE: COMPLAINT ON CANCELLATION OF, OR REFUSAL TO RENEW, HEALTH CARE SERVICE PLAN BENEFITS

The undersigned requests that the Director review the cancellation or refusal to renew the subscription or enrollment for health plan benefits pursuant to Section 1365 of the Knox-Keene Health Care Service Plan Act of 1975, as follows:

1. Name of person whose benefits were cancelled or not renewed:

_____
Full Name – First Middle and Last Names

2. Name of subscriber, if different than "1" above:

_____
Full Name – First Middle and Last Names

3. Name of plan:

_____

4. Subscriber or Enrollee Account or Identification Number:

_____

5. If applicable, the Group Identification Number:

_____

6. Date notice of cancellation or refusal to renew was received:

Date of Notice: _____
Month Day, Year

7. Attach copies of:

(a) The notice of cancellation or refusal to renew received from the plan.

(b) Any correspondence with the plan regarding such cancellation or refusal to renew.

8. State why such cancellation or refusal to renew is believed to be an improper action by the plan:

9. Are you aware of the existence of any grounds for cancellation or refusal to renew under the terms of the agreement with the plan?

❑ Yes ❑ No

10. Explain why you believe that the cause or causes for cancellation enumerated in the notice of cancellation received from the Plan are inadequate or untrue. Attach copies of any documents, which are relevant to your explanation.

11. Does such cancellation or refusal to renew prevent or interfere with providing medical care to any person currently in need of such care?

❑ Yes ❑ No

12. Has the person named in item 1 above whose benefits were cancelled received any medical or health care since the cancellation? If "yes," what services have been received and how much did they cost?

❑ Yes ❑ No

Signature of Complainant:

(b) Upon receipt of a complaint pursuant to subsection (b) of Section 1365 of the Act, the Director will immediately forward a copy of such complaint to the plan, together with a request that the plan furnish the Director with

(1) a copy of the notice of cancellation or refusal to renew,

(2) a copy of any correspondence relating thereto,

(3) a statement of the reason for such cancellation or refusal to renew and

(4) a response to the complainant's allegations pursuant to Item 9 of the complaint form in subsection (a). Such information shall be returned to the Director by the plan within 10 business days following its receipt of the Director's request.

(c) Following examination of the information provided pursuant to subsection (a) and (b), the Director will notify the complainant and the plan of the determination of whether or not a proper complaint exists under the provisions of Subdivision (b) of Section 1365 of the Act.